Mindfulness: valuable medicine for patients and clinicians?

Mindfulness can be described as an attentive awareness of the reality of things in the present moment that can impart power when coupled with a clear comprehension of what is taking place, or put another way, as a calm awareness of body, mind, and spirit supporting analysis that can lead to wisdom. Although many of us promote this practice to our patients to help them more fully live their days whether few or many, it is worth considering how this consciousness could help us, practicing oncologists, through the challenging changes we currently face in our clinical practices and to more fully participate in the transitions to high-quality cancer care, as was recently outlined in a report by the Institute of Medicine.[1]

The report emphasizes that "studies indicate that cancer care is often not as patient-centered, accessible, coordinated, or as evidence-based as it could be, detrimentally impacting patients." Mindfulness in clinical practice would marry the scientific principles of medicine and the patient-centered art of medicine to forge a system that is better aligned with the principles of high-quality cancer care. The report recommends "a conceptual framework" for improving the quality of cancer care, which includes patients who are engaged in decisions about their care; an adequately staffed, trained, and coordinated workforce; the use of evidence-based care to inform decisions about therapies and disease management; improved information technology that can generate "real-time" analyses of patient data and thus allow for the rapid translation of evidence into clinical practice; measurement of quality of care and improvements in performance; and care that is accessible and affordable.[1]

As we finish what I believe has been a tipping-point year in community oncology, we have seen a third of community oncology practices join larger systems of care, according to a report by the Community Oncology Alliance (see p. 368).[2] (It's important to note that the report does not reflect the impact of the sequester cut to cancer drugs, which is expected to further fuel hospital acquisitions of community clinics.) Many other practices have continued to close satellite clinics or even the entire practice, and some have been forced into bankruptcy. Both community and academic clinicians note increasing demands for them to see, care for, and treat higher numbers of ever more complex patients under flawed payment systems that incentivize treatment over high-quality cancer care to improve a patient's overall health. However, a ray of light on the horizon of this burgeoning clinical care crisis is the growing number of health plan, health system, and clinician pilots for what has become known as the medical oncology home. The MOH involves a change in practice culture that involves team-based care that fully engages patients, clinicians, and payers in a patient-centered care system that delivers the most cost-effective care while minimizing suffering and maximizing a patient's health throughout his or her life. Aligned payment methodologies are being piloted, as are data-entry and analytic systems for monitoring the delivery and costs of care, outcomes, and quality metrics, which will contribute to an ongoing learning environment that will allow for real-time improvements in care and health outcomes as well as more transparency for consumers to choose their care teams.

While the care delivery system is grappling with these challenges and changes, there have been significant scientific advances in the field of oncology this year. Among the therapies for breast cancer approved by the Food and Drug Administration this year were everolimus with aromatase inhibitor for patients who have progressed on initial hormone therapy for metastatic disease[3] and

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ado-trastuzumab emtansine, an antibody-drug conjugate, which was finally approved for subsequent line HER2-positive metastatic breast cancer after progression on targeted therapy.[4] An FDA panel recommended approval of pertuzumab for first-line metastatic breast cancer with a taxane and transtuzumab[5] and recently added approval for use neoadjuvantly in HER2-positive patients with chemotherapy to reduce tumor size for breast conservation.

In chronic lymphocytic leukemia (CLL), progress was made in prognostic markers[6] as well as in new drug development with oral idealalisib,[7] and obinutuzumab plus chlorambucil was approved for elderly patients.[8] Ibrutinib plus chlorambucil was approved for previously untreated patients with CLL,[9] while chimeric antigen receptor–modified T-cell therapy therapy[10] as well as continued work on dendritic cell therapy brought hope for longer disease control, better tolerance and more targeted therapies for affected patients.

In leukemia, imatinib was approved for children with Philadelphia chromosome–positive acute lymphoblastic leukemia.[11] For mantle cell lymphoma, the FDA approved the use of lenalidomide for patients whose mantle cell lymphoma has relapsed or progressed after prior therapy[12] and approved the Bruton's tyrosine kinase inhibitor, ibrutinib, for the treatment of patients with mantle cell lymphoma who have received at least 1 prior therapy.

In myeloma, the FDA approved pomalidomide for advanced disease.[13] The agency also approved a new imaging agent, choline C 11, for the detection of recurrent prostate cancer.[14] And in melanoma, the FDA approved two more drugs, dabrafenib and trametinib for metastatic or unresectable melanoma,[15] while progress was made improving survival with ipilumumb by adding the granulocyte macrophage colony-stimulating factor, sargramostim, or surgery,[16,17] and with the investigational PD-1 inhibitor, nivolumab.[18]

Finally for lung cancer, the FDA approved the cobas EGFR Mutation Test, a companion diagnostic test to detect epidermal growth factor receptor gene mutations.[19] Research advanced with PD-L1 agents and anti-PD1 antibodies, which provide a very promising new mechanism for reactivating patients' T cells against various cancers. For now, advances were reported using the PD-L1 agent, nivolumab, with studies advancing in melanoma[18] and with an anti-PD1 antibody in renal cancers.[20]

As we close our ninth year of publishing COMMUNITY ONCOLOGY, we are mindful of expressing our gratitude for our oncology colleagues who share our commitment to advancing the research and delivery of the latest evidenced-based care in supportive and sustainable healing systems. In this spirit, we are excited to announce that effective January 2014, we will be merging our journal with our well-respected sister publication, THE JOURNAL OF SUPPORTIVE ONCOLOGY to form THE JOURNAL OF COMMUNITY AND SUPPORTIVE ONCOLOGY. The combined journal will expand our scope and allow us to bring you the best of the parent journals in articles on the care and support of patients throughout their cancer journey. We look forward to working with the JCSO's combined editorial board. Our Editor in Chief, David Henry; my co-editors, Jame Abraham and Debra Patt; and I are eager to partner with Howard (Skip) Burris, David Cella, and Thomas Strouse in this new venture. We hope you will remain with us in our journey, continue to enjoy the combined journal, and send us your comments and feedback.

We wish you and your families, staff, and patients a mindful and joyful holiday season as we look forward to another exciting and challenging year ahead with our expanded journal and the continued evolution of quality cancer care in the United States.

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